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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32129 32129
State File No. 28

Registration District No. 76212 Primary Registration District No. 53025780 Registrar's No. 28

1. PLACE OF DEATH:

(a) County MILLER
(b) City or town RURAL - Eugene Saline
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community Lifetime years, months or days)

3. (a) PRINT FULL NAME CHARLES - MORGAN

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex MALE 5. Color or race White 6. (a) Single divorced, married, MARRIED
6. (b) Name of husband or wife Adaline Morgan 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased FEB 21 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 7 17 ✓ hr. ✓ min.

9. Birthplace Miller Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business FARMING

12. Name Robert Morgan
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Mary E Jenkins
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Lawrence Morgan
(b) Address Esterville Mo

17. (a) Burial (b) Date thereof 10-10-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARYS HOME Care

18. (a) Signature of funeral director Eldon
(b) Address Mo

19. (a) 10-9-43 (b) Mellie C. Bembush
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MILLER
(c) City or town RURAL - 2 mi So of Eugene
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1943 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 6, 1943, to Oct 8, 1943
that I last saw him alive on Oct 7, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus Lobar Pneumonia Duration 22 days

Due to 108
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature M. P. Humphreys (M. D. or other) DO
Address Tuscumbia Mo Date signed 10-9-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ^{Not} _____, Registered Apprentice No. _____ working under my personal supervision.

Signed

Feith M. Kays

Licensed Embalmer No.

3998

P. O. Address

Eldon Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. oct
Registration District No. _____ Primary Registration District No. _____ Registrar's No. 28

1. PLACE OF DEATH:

(a) County Linn in Miller Co
(b) City or town Eugene Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
RFD #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
address - Eugene RFD #1 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Charles Morgan

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married,
divorced m
6. (b) Name of husband or wife adeline 6. (c) Age of husband or wife if
alive 67 years
7. Birth date of deceased Feb 21
(Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days _____ Unless than one day _____ min.

9. Birthplace mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Miller
(c) City or town Eugene Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RFD #1
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

32129